STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966170	**12/08/2016**
NAME OF PROVIDER OR SUPPLIER **LAUREL OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **3809 CAPPER RD JACKSONVILLE, FL 32218**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

On 8, 2016 an unannounced biennial re-licensure survey with Limited Nursing Services was conducted at Laurel Oaks Assisted Living Facility (License #10423). Deficient Practice was identified during the survey.

0078 Staffing Standards - Staff

Based on document review and staff interview the Facility failed to provide evidence of freedom from documented annually for 2 of 4 employees reviewed (employees A & B).

The findings Include:

1) The file of Employee A with a hire date of / contained evidence of annual testing for performed on / that expired on /. Freedom from ( ) must be documented on an annual basis.

2) The file of Employee B, also with a hire date of / / contained evidence of annual testing performed on /_____ that expired on /_____.

3) During an interview with the Administrator on at 1:50 PM she agreed the annual testing for Employees A & B were outdated and a new test was needed.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

[redacted], 2016

Administrator
Laurel Oaks
3809 Capper Road
Jacksonville, FL 32218

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [redacted], 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than [redacted] 21, 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at [redacted]-4201.

Sincerely,

Jana Meyering, [redacted]
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JS/JM/sm
Enclosure
XG90

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